APPEAL NO. 93119

This appeal arises under the Texas Workers' Compensation Act of 1989 (1989 Act), TEX. REV. CIV. STAT. ANN. arts. 1.01 through 11.10 (Vernon Supp 1993). On January 7, 1993, a contested case hearing was held in (city), Texas, with (hearing officer) presiding. He determined that appellant, claimant herein, reached maximum medical improvement (MMI) on June 22, 1992, with a seven percent impairment rating. Claimant appeals by asserting that the findings and conclusions are in error and that the doctor who did the medical evaluation for the respondent, carrier herein, has changed his mind about MMI. Carrier responds that the decision is based on sufficient evidence.

DECISION

The decision and order are reversed and rendered except insofar as they provide for continued medical benefits.

Claimant had worked as a detention officer for approximately three years on (date of injury) when she slipped on a wet surface by a door, her left foot turned inward and then hit the door. She managed to catch herself on the door but twisted her back in so doing. She wrenched her back and was immediately aware of injury to her lower back and ankle. After assuring that her area was secure, she went to the emergency room of the University Medical Center. (There is no issue in this case as to whether the injury occurred in the course and scope of employment or whether notice was given. The only issues are whether and when MMI was reached, what is the impairment rating if MMI were reached, and is there disability if MMI has not been reached.) Emergency room personnel took x-rays and told her she injured her back without being more specific. Advised to see an orthopedic surgeon, she called (Dr. P) but could not get an appointment for two months. She testified that she needed to see someone sooner and went to her doctor, (Dr. W). Dr. W referred claimant to (Dr. Wo), who practiced physical medicine and rehabilitation. He performed a nerve conduction study and EMG on September 25, 1991. He recorded:

> The definitive denervation potentials do not appear any earlier than about the 15th day and this is only the 11th. Nevertheless, there are enough significant findings in the gastrocnemius, peroneals, hip extensors and paraspinals at the L5 level to warrant concern in regard to the S1 root.

Claimant was able to see Dr. P on September 26, 1991. He performed a thorough physical exam. Dr. P noted that claimant's left leg felt numb to her. He also recorded that she had had an anterior fusion at the L5-S1 level of her back in 1988; he added that symptoms therefrom had resolved. Dr. P indicated that claimant told him the back pain is different this time and her previous problem was never associated with a leg problem. Many tests of movement and reaction are reflected in Dr. P's record for September 26th. One indicated that her deep tendon reflexes were abnormally diminished. Dr. P refers to a very recent MRI which was unremarkable, but refers to Dr. Wo's EMG study as indicating a recent, as opposed to chronic, condition. He believed that a nerve root injury was indicated.

He continued anti-inflammatory medication, referred her to an initial physical therapy program, and said she should return when that physical therapy was complete. He added:

> Not to set a too pessimistic tone here but there is a definite possibility that we could end up with a situation in which we have a patient with a documented quantifiable nerve root injury who does not have spinal level pathology that could be intervened with.

An epidural steroid injection was done on November 8, 1991 at the L5-S1 level. On November 25, 1991 Dr. P states that the physical therapy has not helped. He mentions discography to rule out L4-5 problems, facet block at S-1 and a diagnostic nerve block at S-1. He thinks her pain may be suggestive of a mechanical problem, and referred her to (Dr. R) for the blocks. Dr. R on December 6, 1991, saw the claimant and described discography that he would do on December 16th. On December 16, 1991 Dr. R did the discography and found the L4-5 area to be all right. He recorded that S1 root injections will be considered. On January 20, 1992 , Dr. R found her pain to be worse and stated that epidural hypertonic saline injections might be beneficial; he also considered whether there could be residual disc disease at L5-S1 where the old fusion had been done. On February 5th, steroid injections were made. On February 7th, discography of L3-L4, L4-L5, and L5-S1 was performed; it showed the L5-S1 disc was degenerated and contrast medium was discharged on its posterior side.

On February 20, 1992, Dr. P states that the facet blocks done in early February provided little help. He suggests hypertonic saline injections over a three day period. He adds:

> Surgically, the only thing we have to offer her is a posterior decompression and King facet fusion at L5-S1 with no guarantee of success.

On March 11, 1992, Dr. P then said:

> . . . she has new evidence from a recent EMG of nerve damage. The . . . findings are consistent with new and not old . . . pathology. It may be that we will have to simply decompress and explore, but I really don't like doing that unless it becomes our only alternative. At this point . . . we have not made a decision regarding surgical intervention.

On March 27th, 28th, and 29th the claimant received corticosteroid hypertonic saline and anesthetic for pain control through an inferior epidural catheter. On April 30th Dr. R placed a spinal cord stimulator in claimant. On May 4th, he removed the stimulator noting that the claimant was not ready for a permanent stimulator.

The preceding review of medical data concerning the claimant indicates that she was thoroughly examined prior to any extended treatment, that a treatment plan was initiated, and that the physician in charge of claimant did not routinely adhere to one plan when it provided no improvement. While some of the procedures discussed herein were invasive, they were ordered sequentially as results of prior efforts were noted and possible problems ruled out. As compared to surgery, claimant was treated conservatively for an extended period of time. Surgery was considered but not recommended prematurely. Dr. P considered surgery to be "no guarantee" and looked upon it as a last alternative. Dr. P's caution reflects that some forms of back surgery will at times damage the patient in some way regardless of the possible improvement made in regard to the injury itself.

On June 22, 1992, (Dr. G), a neurosurgeon, upon having been asked by the carrier to examine claimant provided a report indicating MMI on June 22, 1992 with five percent impairment. His report takes into consideration the tests and procedures accomplished at that time. He refers to EMG studies as showing chronic and acute S-1 root changes, but pointed out that MRIs and CT scans were essentially normal. He noted her leg weakness and numbness and referred to the possibility of adhesions from the past surgery which "may have been aggravated" by the September 1991 injury. He says, "I suspect that (claimant's) condition has stabilized." He then goes on to say that her 1988 injury and surgery were responsible for a total of 15 percent impairment out of a total of 20 percent impairment, leaving five percent impairment to the 1991 injury. He concludes, "I would also have to feel that she has reached (MMI)."

Claimant did not agree with that report and a designated doctor was selected by the Commission. That doctor was (Dr. O) who saw claimant (and according to the testimony of claimant, many other claimants) on October 10, 1992 at the Holiday Inn Civic Center in Lubbock. Dr. O's report mentions the initial EMG at 11 days post injury, but no subsequent one; he does mention the normal MRIs. He records that her knee jerks and ankle jerks are diminished. He states that range of motion "is as depicted in the chart. . . ." He does discuss her history of injury and past treatment and noted that she had been given an option to have surgery. He characterized her treatment as conservative. He stated, "[g]iven the history she gives and following my examination, I feel that with progress of time, there will be continued but slow improvement of her residual symptoms." He then added,

> Given the fact that she had been treated for the past year, and her symptoms have stabilized, although she still has residual symptoms, I feel that she has reached [MMI], and I have discussed this with her.

Dr. O then discussed the impairment figure in terms only of range of motion and arrived at 11 percent with four percent being for the original injury, leaving her impairment at seven percent. Notwithstanding his basis for saying that MMI had been reached, quoted above, Dr. O then on the TWCC form 69 stated that MMI occurred on June 22, 1992. This date is

the one attributed to claimant by Dr. G, *supra*. Dr. O never refers to Dr. G's report in his report and gives no reason for selecting that date, nine months post injury, when he conditioned his MMI statement, apparently, on a year's treatment. Accompanying the TWCC form 69 and Dr. O's narrative was an impairment study of two pages introduced into evidence as Carrier's Exhibit No. 4. This report depicted range of motion results. Claimant testified that this part of the exam was performed by a "nurse" who "could not get it right" so Dr. O then showed her how and "walked back out." We note that Dr. O did not discuss claimant's ranges of motion in his narrative except as quoted previously.

Claimant testified that she had had back surgery in 1988 and when injured in 1991, did not want surgery again. She agreed with Dr. P's referral to Dr. R for pain management treatment, but said that the pain got worse and worse. She referred to the numbness she had in her left leg as giving her difficulty in walking and said that she cannot work.

On November 2, 1992, Dr. R reported that he believes she has reached MMI since she does not want to have further surgery. He estimates that her impairment is 15 percent, but adds that her pain could increase in the next years to a point at which she would choose surgery. On November 5, 1992, claimant saw Dr. P and asked him to estimate her impairment. He referred to her weakness in her leg, spasms, and nerve injury and gave a figure of 15 percent. He said that surgery could improve her "but I doubt that even a successful operation will return her to the level that she was at in terms of her function just before she had the most recent injury . . ." (emphasis added). He also added that she should think very carefully about it before "running into the operating theater."

On November 12, 1992, Dr. P then writes that the claimant came back saying "her present situation is untenable" and will have surgery. Dr. P then opines that the pending surgery negates any conclusion of MMI. He says he will have to expose the S1 nerve roots which will result in more pain for a period. He estimates six to eight months after surgery "to get a solid fusion" and three to four more months thereafter for rehabilitation. He estimates that the earliest time for MMI would be in the 10th post-operative month.

The carrier sought a second opinion for this surgery and (Dr. C) on December 9, 1992 provided his opinion for the carrier. He said "I therefore agree with the planned surgery by (Dr. P). . . ." He noted the "extensive efforts at conservative treatment . . ." claimant had undergone.

Surgery was performed on December 15, 1992, with claimant then discharged on December 21, 1992. Dr. P's operative report reflects that it was typed on December 29, 1992. Her surgery was described as "L5-S1 King facet screw fusions. Decompression of the lateral recesses and the sub-facet zones L5-S1 bilaterally. Inter-transverse posterolateral fusion L5 to S1, EBI stimulator placement, and placement of epidural catheter for postoperative pain management."

At the hearing on January 7, 1993, claimant testified that she developed some respiratory problems after the surgery and feels as if she was "run over by a train" because of the trauma of the surgery. She added that she now has some feeling in her left leg and the pain that she had in her back is better, but the effects of the surgery are painful.

The hearing officer applied the presumption found in Article 8308-4.25 of the 1989 Act and found that MMI had been reached as stated by Dr. O. He said also that the surgery did not change this finding.

This decision on review does not take the position that surgery after a designated doctor's report will always change a determination of MMI, but in this case surgery was a viable option for treatment recognized throughout the process of more conservative treatment, as previously discussed. Also, we considered that the carrier's second opinion as to surgery concurred in the surgery immediately before it occurred. In addition, the record showed that the surgery of December 15, 1992 stemmed from the injury of September 1991 and was not frivolously delayed for reasons other than good medical practice. The statement of Dr. P on November 12, 1992, not only says that MMI has not been reached, it gives a detailed estimate of recovery time from December 15, 1992. In addition, claimant's testimony at the hearing and the hearing officer's concern for her during the hearing point to the fact that she had not recovered from the surgery at the time of the hearing.

In comparing medical evidence, each expert's opinion should be considered in terms of its thoroughness and credibility. Such evidence is subject also to tests of consistency and accuracy. In addition this evidence may be considered in regard to the basis or foundation it provides for opinions that are set forth. Dr. P's report of November 5th can be viewed as inconsistent with his report of November 12th; one said MMI was reached, while the subsequent one said it had not. Dr. P, however, explained the different opinions, not only in the latter one, but qualified the first one at the time given as viable because surgery had not been chosen. On the other hand, the designated doctor's report is not as thorough because it does not have all the information available at the time of the hearing. We also view that the designated doctor was inconsistent in prefacing his MMI decision on treatment for the "past year" and then assigning MMI a date, nine months after the injury, without further explanation. He may also appear to be inconsistent in referring to "continued but slow improvement of her residual symptoms." This can raise a question, but is not necessarily inconsistent with a finding of MMI since Article 8308-1.03(32) provides in defining MMI that recovery should be expected to be "material" to delay MMI. Giving Dr. O's statement as to improvement the benefit of the doubt, it still does not overcome the problems of thoroughness and inconsistency in the designated doctor's report discussed above.

In reviewing Dr. O's report placing MMI on June 22, 1992, we may contrast that report with the full explanation given by Dr. P throughout his reports, including his discussion of the pending surgery and the reasons why he believes that MMI has not been reached. There is also significant consistency among doctors other than the designated doctor. Dr. R only considered MMI to be a possibility because the claimant did not want surgery. Dr. C, on behalf of the carrier, agreed with the surgical plan of Dr. P. Claimant testified that neither Dr. O or Dr. G has seen her or her records since they gave their opinions.

The case before us shows that if there were no surgery contemplated, the great weight of the medical evidence would not be contrary to a determination of MMI; but because of the problems with the designated doctor's report and the efficacy of other medical evidence, the date of MMI could be in question. The great weight of medical evidence became contrary to the designated doctor's report in regard to whether MMI has been reached when the surgical option in this case was implemented. The facts herein show that the hearing officer's determination that the great weight of other medical evidence was not contrary to the designated doctor's report was against the great weight and preponderance of the evidence. In reaching this decision, we do not indicate that the "unique position of the designated doctor's report" is diminished, but simply that it may be overcome as set forth in the 1989 Act. *See* Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. *See also* Texas Workers' Compensation Commission Appeal No. 93095, decided March 19, 1993, in which the decision of the hearing officer to use the designated doctor's opinion was reversed and remanded to develop evidence based on a claimant's testimony of the absence of the designated doctor in the evaluation process.

Separately, and not the basis for the decision to reverse and render, is the added evidence provided by the claimant which would allow the case to be remanded if that were necessary. When Dr. P's surgical report was offered at the hearing on January 7, 1993, the carrier objected on the basis of late exchange. The carrier in arguing for exclusion referred to claimant as having just received the report that day. (The surgical report shows that it was dictated on December 21st and typed on December 29th so receipt on January 7th does not appear inconsistent.) The hearing officer correctly admitted the surgery report by finding good cause for the untimeliness of exchange. At the end of the hearing, the hearing officer left the record open for briefs (his comments did not rule out added evidence). Within the time period provided by the hearing officer, claimant filed a brief dated January 15th within which she alluded to sending a copy of the surgery report to the MEO, Dr. G, for his comment. A response was received which was attached to the appeal. It said that the MEO retracted his MMI date (which date the designated doctor had thereafter picked as his own for some unexplained reason). The standards set forth for remand (*see* Black v. Willis, 758 S.W.2d 809 [Tex. App.-Dallas 1988, no writ]) which ask when did the material come to claimant's knowledge, is it cumulative, was diligence exercised in getting the material, and would it probably produce a different result, are present in this situation. The hearing officer

could consider Dr. G's statement on remand, but, as stated, such is not necessary in this case.

The decision and order are reversed and a new decision rendered that the claimant has not reached MMI at the time of the hearing. Income benefits are payable under the provisions of Article 8308-4.21 and other pertinent provisions of the 1989 Act and decisions of the Appeals Panel. Claimant remains entitled to medical benefits.

Joe Sebesta
Appeals Judge

CONCUR:

Stark O. Sanders, Jr.
Chief Appeals Judge

Susan M. Kelley
Appeals Judge